HMA
HEALTHCARE MANAGEMENT ADMINISTRATORS

Baden Sports (Group # 4078)
HEALTH PLAN ENROLLMENT FORM
Plan year: 8/1/2020 – 7/31/2021

☐ **Open Enrollment** ☐ **New Enrollee** ☐ **Coverage Change** ☐ **Name Change** ☐ **Address Change**

☐ Drop Spouse/Dependent Reason: _____

☐ Add Spouse/Dependent Reason: _____

If Adding Spouse, Date of Marriage: _____
(If adding dependent(s) due to adoption, court order, or legal guardianship, you must provide legal documentation.)

☐ Rehire Date: ____/____/____ ☐ Leave of Absence Date returned from LOA: ____/____/____

Employee Information

Soc. Sec. #_____ **Date of Birth** _____/_____/_____ **Sex:** ☐ **M** ☐ **F** **Telephone Number** (___)_____

Last Name _____ **First Name** _____ **M.I.** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Email Address_____

Benefit Elections

Medical/Rx Plan Election
☐ Core Plan ☐ Buy-Up Plan

Medical/Rx Election
☐ Employee
☐ Employee & Spouse
☐ Employee & Children
☐ Employee & Family
☐ Waive

Dental Election
☐ Employee
☐ Employee & Spouse
☐ Employee & Children
☐ Employee & Family
☐ Waive

Vision Election
☐ Employee
☐ Employee & Spouse
☐ Employee & Children
☐ Employee & Family
☐ Waive

List below all dependents (Spouse/Children) you wish to cover: (sex, date of birth, and social security number required)

First Name	M.I.	Last Name	Sex	Date of Birth	Relationship SP=Spouse D=Daughter S=Son	Social Security # *Required
					SP	

If dropping spouse/dependent please list name(s):

Name: _____ Termination date: _____ Reason: _____

Name: _____ Termination date: _____ Reason: _____

List any dependent who is developmentally disabled or physically handicapped who is over age 25:

Name: _____ (Medical documentation must be submitted within 31 days of the effective date of coverage.)

This section MUST be completed in order for your enrollment to be processed.

Coordination of Benefits Information

Is there anyone enrolling on the plan who currently has coverage through another insurance plan? ☐ Yes ☐ No

If yes, please complete the following:

Marital Status: ☐ Single ☐ Married_____ ☐ Widowed ☐ Legally Separated ☐ Divorced
Name of Spouse/Domestic Partner

If divorced, is there a court order for provision of the child? ☐ Yes ☐ No If yes, please attach a copy of the court decree. Per court decree:

Who has custody of child? _____ Who provides insurance for child? _____

Please list the full name of the child(ren) _____

_____

Please list both the natural parents name and date of birth:

Natural Father _____ / DOB _____ Natural Mother _____ / DOB _____

List all family member(s), including yourself, who are included on this enrollment form and are currently covered through another plan.

Name of covered members:	Type of Coverage: (M)edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage:	Carrier Name:
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____

Provide the following information on the carriers listed above:

Carrier Name: _____ Policy Number: _____

Street Address: _____ City: _____ State _____ Zip _____

Carrier phone #: _____

Subscriber's Name: _____ Social Security Number: _____ Date of birth: _____

Employer's Name and Address (if group coverage) _____

Is Employee, Spouse/Domestic Partner covered under this medical plan eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility for Medicare Part A _____ date of eligibility for Medicare Part B _____

Social Security No._____

_____

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. *By signing this form, I attest that all dependent children listed for coverage are under age 26.* I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent.

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. *

Health information requested or disclosed may be related to treatment or services performed by: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available from the Baden Human Resources Department upon request.

Employee's Signature_____ **Date Signed** _____/_____/_____

EMPLOYER SECTION

Date Hired: _____/_____/_____ Coverage Effective Date: _____/_____/_____

Late Enrollment: ☐ Yes ☐ No Special Enrollment: ☐ Yes ☐ No (If yes, attach waiver of health coverage)

Certified by: _____ Today's Date: _____/_____/_____